DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445141	A. BUILDING _____ B. WING _____	R 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY HEALTH CARE & REHAB	2910 PEERLESS RD CLEVELAND, TN 37312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A revisit was completed at Bradley Health Care and Rehab on November 10, 2011, following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy for F225, F250, F280, F323, F490 and F520. The revisit revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy but noncompliance continues at F225 "D" level, F250 "E" level, F280 "E" level, F323 "E" level, F490 "E" level and F520 "E" level, as evidenced by the findings. Other deficiencies previously cited and not addressed on the Allegation of Compliance remain outstanding. The facility is required to submit a plan of correction for all outstanding deficiencies including the Immediate Jeopardy deficiencies lowered in severity and scope.	{F 000}		
{F 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to complete a pre-restraint assessment and a physical restraint reduction assessment for one resident (#3) of forty-nine residents reviewed.	{F 221}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Joseph H. Newcomb / per le Her | | 11/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 221}	Continued From page 1 The findings included: Resident #3 was admitted to the facility on July 10, 2007, with diagnoses including Paraplegia, Brain Injury, and Seizure Disorder. Medical record review of the Minimum Data Set (MDS) dated September 23, 2011, revealed the resident was totally dependent for transfers, required extensive assistance with all activities of daily living, independent for decision making, and behavioral symptoms occurred four to six days a week. Medical record review of the Falls Prevention Program Interventions dated March 10, 2010, and last updated March 12, 2011, revealed "...hand mittens on at all times..." Medical record review of the Interdisciplinary Plan of Care dated July 5, 2011, revealed, "...non-compliance with Gastric Tube (G-Tube) Placement (feeding tube)...pulling G-Tube out multiple times...remove restraint devices daily..." Medical record review of the Physician's Orders dated October 1, 2011, revealed, "...keep mittens on...at all times..." Medical record review revealed no documentation of a pre-restraint assessment or a restraint reduction assessment. Observations on October 18, at 6:00 a.m., in the resident's room, revealed the resident lying in the bed with bilateral hand mittens in place and at 11:30 a.m., at the Wing Two Nurses' Station, revealed the resident in the wheelchair with	{F 221}	A. Resident #3 was evaluated , pre -restraint evaluation was completed and restraint was continued as ordered. Need for restraint will be reviewed by nursing, therapy, SS, pharmacy consultant, medical director, and administrator & noted on restraint elimination form with appropriate action taken. Pre-restraint and restraint elimination was completed 10/20/11. B. All residents with restraints or need for restraint have the potential to be adversely affected by this deficient process. Residents will be assessed & pre-restraint assessment form will be completed at time of assessment and restraint elimination will be discussed in sub QA meeting or when medical symptom has abated. C. Restraint assessment forms will be brought to the weekly sub QA meetings & completed at that time. Interventions and/or changes will be discussed at the following meeting & changes will be made at that time if not already done. D. Nursing management, medical director, rehab, pharmacy consultant, social service staff will meet weekly and prn to review appropriateness and effectiveness of interventions and assessment forms information. Changes and/or reductions will be made as needed.	11/11/11

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{F 221}	Continued From page 2 bilateral hand mittens in place. Further observations on October 19, 2011, at 8:00 a.m. and at 3:40 p.m., at the Wing Two Nurses' Station, revealed the resident sitting in the wheelchair with the bilateral hand mittens in place. Interview with Registered Nurse #1 on October 18, 2011, at 12:05 p.m., in the Wing Two Nurses' Station, confirmed the bilateral mittens were in place to prevent the resident from pulling the G-Tube out and the facility failed to complete a pre-restraint assessment and a physical restraint reduction assessment for the hand mittens.	{F 221}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	{F 225}	A. Resident #12-Discovered bruise on July 22, 2011. Clinical manager reviewed accounts July 25, 2011 given by nurse and CNA on duty during initial discover. ADON reviewed account on July 25, 2011. Reopened investigation 10/28/11. ADON re-interviewed nurses and CNA's on duty during initial discovery. Investigation was completed 11/1/11. No other action was required. No intentional injury occurred based on resident behavior and reaction to others was unchanged, no further incident of this type has recurred. Abuse coordinator reviewed all documentation on 11/1/11 of investigation and no abuse was substantiated per clinical assessment. The medical director was notified by DON on October 25, 2011. NP was notified by DON on October 28, 2011. Medical director	11/11/11

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{F 225}	Continued From page 3 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation review, policy review, and interview, the facility failed to thoroughly investigate and report an injury of unknown origin for one (#12) of forty-nine residents reviewed. The facility's failure to thoroughly investigate and report an injury of unknown origin placed resident #12 in immediate jeopardy. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation, has caused or is likely to cause, serious harm, injury, impairment or death. The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-225 continues at a "D"	{F 225}	& NP were notified of investigation completion on 11/8/11 by DON. No further orders were given. State guardian was notified 11/1/11. In-servicing on abuse policy, unknown origin, and behavior management policy began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Revised abuse policy on November 6, 2011 was combining unknown injuries/accident incidents to be included in policy. No new information was added. State was notified of incident & investigation through IRS system on 11/7/11. B. All residents with incidents of unknown origin have the potential to be affected by this deficient process. Incident reports from July 22, 2011 to current were reviewed by ADON on 11/7/11 and review of 44 unknown incidents required no further action. Incidents of unknown origin are being reviewed by nursing management initially (daily as occurrence) and ADON (QA nurse) receives incident, and the investigation begins immediately, the abuse coordinator and administrator immediately receive copy of incident as notification to begin investigation. MD/NP will be notified of each	

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{F 225}	Continued From page 4 level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided evidence of a completed investigation of the bruising of unknown origin of resident #12. In addition, the Assistant Director of Nursing (ADON) provided the findings and conclusions from the investigations of forty-four additional injuries of unknown origin. The ADON provided the methods adopted to facilitate the identification of all injuries of unknown origin, communication to all responsible parties, investigation of the injuries to a conclusion, and the system to track and trend the injuries. The facility provided new policies/procedures including a policy for investigation of injuries of unknown origin adopted as part of the abuse policy, The facility provided evidence of in-service education for all staff. The facility will remain out of compliance at a "D" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 225}	(F225) D. Incidents will be reviewed and discussed in the weekly meeting with nursing admin., rehab department rep., pharmacy consultant, medical director, administrator, and any other appropriate staff according to nature of incident.	
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	{F 241}		

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{F 241}	Continued From page 5 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain dignity for one (#19) of forty-nine residents reviewed. The findings included: Resident #19 was admitted to the facility on June 4, 2010, with diagnoses including Atrial Fibrillation, Depressive Disorder, Osteoporosis, Chronic Airway Obstruction, Diabetes, and Gout. Medical record review of the Minimum Data Set dated August 30, 2011, revealed the resident was independent with daily decision making. Observation on October 19, 2011, at 8:20 a.m., revealed resident the seated at a table with three other residents eating the breakfast meal. Continued observation revealed Licensed Practical Nurse (LPN) #1 approached the resident and administered nasal spray into both nostrils and administered an insulin injection into the resident's left arm. Interview on October 20, 2011, at 9:20 a.m., with the resident, in the resident's room, revealed the resident did not like to receive the nasal spray and insulin injection, in the dining room. Interview on October 19, 2011, at 9:20 a.m., with the Director of Nursing (DON), in the DON's office confirmed the resident's dignity was not	{F 241}	A. Resident #19 will not receive meds in dining room which compromise dignity (only po meds). B. All residents in dining rooms have the potential to be adversely affected by this deficient process. In-servicing On med pass in dining room and compliance rounds by nursing administration was completed by November 14, 2011 and is ongoing. C. Compliance rounds weekly and prn by nursing administration will ensure compliance with med administration in dining rooms. D. Weekly and prn compliance rounds by nursing administration and med rounds with pharmacy consultant will be ongoing and compliance assured.	11/14/11

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{F 241}	Continued From page 6 maintained.	{F 241}		
{F 246} SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the call light had been adapted for use for one resident (#3) of forty-nine residents reviewed. The findings included: Resident #3 was admitted to the facility on July 10, 2007, with diagnoses including Paraplegia, Brain Injury, and Seizure Disorder. Medical record review of the Minimum Data Set (MDS) dated September 23, 2011, revealed the resident was totally dependent for transfers, independent for decision making, and behavioral symptoms occurred four to six days a week. Medical record review of the Falls Prevention Program Interventions dated March 10, 2010, and last updated March 12, 2011, revealed... " hand mittens on at all times...call light in reach and encourage resident to call for assistance..."	{F 246}	A. Resident #3 had an appropriate appropriate position sensitive call light placed on 10/25/11. B. All residents unable to use traditional call lights have the potential to be adversely affected by this deficient process. All residents were reviewed by nursing management with appropriate call lights in place. Residents will be identified by nursing assessment on admission, quarterly, and prn and an appropriate call light will be put in place. C. Nursing assessment on admission, weekly, monthly, & with change of condition will be performed. If resident is identified as unable to use call light nursing with rehab assessment will determine appropriate call light and it will be placed. D. Nursing management will conduct compliance rounds weekly and will review resident ability to use appropriate call light with daily observation, weekly compliance rounds & quarterly CP meetings.	11/11/11

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{F 246}	Continued From page 7 Medical record review of the Interdisciplinary Plan of Care dated July 5, 2011, revealed "...At risk for falls R/T (related to) impaired physical mobility...keep call light within reach while in bed..." Medical record review of the Physician's Orders dated October 1, 2011, revealed "...keep mittens on at all times..." Observations on October 18, 2011, at 6:00 a.m., in the resident's room, revealed the resident lying in the bed, bilateral hand mittens in place, a floor mat present, and a button call light tied to the right side rail. Interview with Registered Nurse (RN) #1 on October 20, 2011, at 9:05 a.m., in the Wing Two Nurses' Station, confirmed the bilateral mittens were in place at all times while the resident was in the bed, the resident rolls self out of bed for attention, and the resident could not manipulate the call light with the mittens in place. Further interview confirmed the facility failed to provide a call light the resident could use while the bilateral mittens were in place.	{F 246}		
{F 250} SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 250}	A. Resident #12 has had a behavior component added to her Care Plan 10/28/11 by social service assistant assigned to that resident. After SS director (LCSW) assessed resident, on 10/28/11 an individualized written behavior management plan was formulated, and then SS director in-serviced nursing staff on plan and placed plan in chart on 10/28/11 and also copy of plan placed in Behavior	11/11/11

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{F 250}	Continued From page 8 Based on medical record review, observation, and interview, the facility failed to provide social services adequate to meet the needs of four residents (#12, #15, #27, & #30) of four residents reviewed with behaviors affecting other residents. The facility's failure to provide social services adequate to address the resident to resident behaviors placed the residents on Wing I and IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-250 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided new policies/procedures including a policy for Behavior Management. The facility provided evidence of in-service education for all staff for the adopted behavior management policy and for specific resident behavior management plans, The individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 27, and 30. Resident #15 had been dismissed from the facility. In	{F 250}	Sheets book at nurses station. Resident #15 has had a behavior component added to his care plan 10/27/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, on 10/27/11an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. One on one was already in place and continued until out to hospital for unrelated medical issues on 11/3/11. Resident #27 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. Resident #30 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on	

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{F 250}	Continued From page 9 addition, the behavior management plan for the single resident presenting with a new behavior on November 8, 2011, was reviewed. The behavior management plan to address this resident's new behavior was inserviced for the staff caring for the resident on November 9, 2011. Observation confirmed each of these residents also had the behavior management plans filed at each nursing station with an accompanying grid to facilitate recording behaviors. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 250}	discussions/updates. Behavioral issues will be logged on a Behavior tracking form and reviewed for trends as each incident occurs and will be reviewed at weekly meeting and trends & interventions will be reported at monthly QA meeting. QA nurse will track & trend behavior issues.	
{F 278} SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	{F 278}		

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{F 278}	Continued From page 10 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for three (#14, #15, and #31) of forty-nine residents reviewed. The findings included: Resident #14 was admitted to the facility on September 10, 2007, with diagnoses including Cerebrovascular Accident, Motor Vehicle Accident with Traumatic Brain Injury, Convulsions, and Rosacea. Medical record review of the MDS dated October 11, 2011, revealed the resident had experienced a fall without injury, since the prior MDS assessment. Review of the medical record revealed no documentation the resident had experienced a fall. Interview on October 18, 2011, at 2:00 p.m., with the Director of Nursing, in the file room,	{F 278}	A. Resident #14, MDS dated 10/11/11 was corrected on 10/20/11 to reflect no fall occurred. Resident #15's MDS dated 10/11/11 did not reflect dementia related to severity of other diagnosis but CP was completed re: dementia on 11/1/11. Resident #31's MDS dated 9/27/11 was corrected on 10/24/11 to reflect a fall had occurred. B. All residents have the potential to be adversely affected by this deficient process. MDS will be reviewed when completed prior to submission by IDT and any changes needed will be addressed. The dementia diagnosis will be listed as diagnosis in an order which will place dementia on MDS if not captured otherwise. C. Nursing will notify MDS nurse verbally during weekly sub QA meeting and in writing by updated roster at least weekly. D. MDS will be reviewed quarterly and change of condition for accuracy by IDT. Nursing management and MDS nurse to monitor for complete assessment accuracy & MDS review prior to submission at MDS meeting.	11/11/11

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{F 278}	Continued From page 11 confirmed the resident had not experienced a fall since the prior assessment, and confirmed the MDS dated October 11, 2011, was not accurate. Resident #15 was admitted to the facility on July 9, 2011, with diagnoses including Dementia, Ischemic Heart Disease, and Pressure Ulcer. Medical record review of the MDS dated July 13, 2011, and October 11, 2011, revealed no documentation of the Dementia diagnosis. Interview on October 19, 2011, at 10:00 a.m., with Licensed Practical Nurse (LPN) #2, in the conference room, confirmed the MDS dated July 13, 2011, did not include the resident's diagnosis of Dementia. Resident #31 was admitted to the facility on April 2, 2001, with diagnoses including Personal History of Fall, Peripheral Vascular Disease, and Blepharitis. Medical record review of the MDS dated September 27, 2011, revealed the resident had not experienced a fall since the prior MDS assessment. Medical record review of the nursing notes dated August 8, 2011, revealed "CNA (Certified Nursing Assistant) came to...et (and) stated 'pt. (patient) is in the floor.' Upon entering DR (dining room) pt was lying on (L) side...(no) inj. (Injury) noted..." Interview on October 21, 2011, at 9:35 a.m., with LPN #2, in the conference room, confirmed the MDS dated September, 27, 2011, did not reflect the resident's fall on August 8, 2011, and	{F 278}		

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{F 278}	Continued From page 12 confirmed the MDS was not accurate.	{F 278}		
{F 280} SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation review, observation, and interview the facility failed to assess for and implement a care plan addressing behavior signs and symptoms for five residents (#12, #15, #24, #27, and #30) and the facility failed to care plan for the assessed number of assistants required for transfer for one resident (#8) of forty-nine residents reviewed.	{F 280}	A. Resident #12 – Social service director assessed resident and formulated behavior management plan on 10/28/11. Care plan was updated on 10/28/11 by social service assistant assigned to resident. In-servicing on behavior management plan to direct care staff was 10/28/11 by social service director. Nursing management & SS staff will monitor effectiveness of interventions through behavior monitoring sheets, incident reports, daily observations, and interviews. Monitoring sheets are completed by nurses as part of their documentation, and in-servicing is done on orientation and any questions are answered by nurse managers at any time. Resident #15 – Social service director assessed resident and formulated behavior management plan on 10/27/11. Care plan was updated on 10/27/11 by social service assistant assigned to resident. In-servicing on behavior management plan to direct care staff was 10/28/11 by social service director. One on one care was currently in place while up in w/c, staff was scheduled, documentation reflects the continuation of one on one and assigned staff was relieved by other assigned staff for breaks.	11/11/11

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{F 280}	Continued From page 13 The facility's failure to assess and implement a careplan to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-280 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of care plans, observation, and interview with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 24, 27, and 30. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 280}	Resident currently in hospital for unrelated medical issue as of 11/3/11. Restraint was placed on CP by nursing management and behaviors regarding self harm & negative interactions by social assistant on 10/27/11. Nursing management & SS staff will monitor effectiveness of interventions through behavior monitoring sheets, incident reports, daily observations, and interviews. Monitoring sheets are completed by nurses as part of their documentation, and in-servicing is done on orientation and any questions are answered by nurse managers at any time. Resident #24 – Bruising to breast related to wheelchair has been assessed by nursing and rehab and a different w/c was issued to resident on 11/4/11. This w/c is tagged with resident name & staff in-serviced by CM on chair & positioning on 11/4/11. Clinical Manager added this to CNA CP also on 11/4/11. Nursing staff will observe at least every 2 hours on rounds & prn regarding positioning in w/c and ask resident regarding comfort. Bruising and prevention has been added to CP by nursing management after assessment as of 10/31/11. Resident #27 – The CP has been updated to reflect behaviors and interventions by social service	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		

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{F 280}	Continued From page 13 The facility's failure to assess and implement a careplan to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-280 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of care plans, observation, and interview with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 24, 27, and 30. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 280}	assistant on 10/28/11 and behavior management plan was implemented by social service director and in-serviced nursing staff on 10/28/11. Resident #30 – Behavior management plan was formulated after assessment by social service director on 10/28/11. SS director in-serviced nursing staff on 10/28/11. Social service assistant updated CP to address behaviors on 10/28/11. Resident #8 –This resident was a 4 person transfer as of 6/3/11 & nursing staff was in-serviced by rehab on that date. CP updated to reflect transfer needed. Resident expired 11/13/11. In-servicing on abuse policy, behavior management policy, & incidents of unknown origin policy began on 10/28/11 and all staff to be in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. B. All residents have the potential to be adversely affected by this deficient process. All CPs have been reviewed for accuracy on 11/7/11 by MDS nurses, social service staff, nursing management, and updates completed. In-servicing of updates to direct care staff done by nursing management completed 11/8/11. All staff on vacation or leave will be in-serviced	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		

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{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		

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{F 280}	Continued From page 13 The facility's failure to assess and implement a careplan to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-280 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of care plans, observation, and interview with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 24, 27, and 30. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 280}	& nurses also aide in developing interventions. Transfers are reviewed by rehab on new admissions, readmits, upon referral and annually. In-servicing of direct care staff (CNA's & nurses) is done on an individual resident basis after rehab assessment. C. IDT will conduct weekly sub QA meetings to discuss pertinent information regarding residents identified as above. The purpose of this meeting is to determine an interdisciplinary approach to resident care. D. IDT will monitor effectiveness of CP interventions by observation, using monitoring tools such as behavior monitoring sheets, incident reports and referrals to specific departments. Each department representative of the IDT will monitor effectiveness of the CP interventions within their scope of responsibility and expertise.	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		

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{F 282}	Continued From page 14 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to maintain an accurate record of fluid intake and output for one resident (#18) of forty-nine residents reviewed. The findings included: Resident #18 was admitted to the facility on December 15, 2010, with diagnoses including Left Lower Quadrant Open Abscess, Acute Renal Failure, Sepsis, Chronic Obstructive Pulmonary Disease, and Dementia. Medical record review of the resident's care plan updated October 5, 2011, revealed "category problem...Catheter: indwelling...with potential risk of UTI (urinary tract infection) intervention...Change foley...empty foley every shift and record output..." Medical record review of the facility intake and output record for resident #18 revealed incomplete documentation September 1, 2011 through October 18, 2011, to provide an evaluation of the resident's overall fluid intake and output. Review of the facility policy for Intake and Output	{F 282}	A. Resident #18's fluid intake and output is current as of 10/19/11. B. All residents determined to need an I & O per policy and those specifically ordered by MD/NP have the potential to be adversely affected by this deficient process. In-servicing of nurses re: I & O policy was completed by November 14, 2011 by nursing management and is ongoing. C. Chart audits and nurses in-services will be conducted by nursing management to ensure compliance. Residents requiring I & O's will be identified and a log will be kept, reviewed by nursing management daily to ensure compliance. D. Nursing management will review & monitor all resident documentation regarding fluid intake & output and assure completion of documentation and notification to MD/NP as needed.	11/14/11

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{F 282}	Continued From page 15 revealed, " ...total intake for 24 (twenty-four) hour cycle...total output at the end of each tour of duty. Key point: total for 24 hour cycle..." Interview with the Wing I Clinical Manager (CM) and the Director of Nursing, in the CM's office on October 19, 2011, at 8:45 a.m., confirmed the facility policy for intake and output was not followed.	{F 282}		
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide nail care for one resident (#3) of forty-nine residents reviewed. The findings included: Resident #3 was admitted to the facility on July 10, 2007, with diagnoses including Paraplegia, Brain Injury, and Seizure Disorder. Medical record review of the Minimum Data Set (MDS) dated September 23, 2011, revealed the resident was totally dependent for transfers and required extensive assistance with all activities of daily living.	{F 312}	A. Resident #3 nail care was done on 10/19/11 with all nails trimmed and no jagged edges. B. All residents have the potential to be adversely affected by this deficient process. Compliance rounds will be completed weekly & prn by nurse/nursing management in regards to resident care including hygiene & personal appearance. Care needs will be addressed and CNA's & nurses were in-serviced by nursing management re: nail care by November 14, 2011 & ongoing. C. Nurses and nursing management will conduct weekly/prn compliance rounds to ensure ADL care is provided for all residents according to their level of care. D. Nursing management will monitor for nail care with compliance rounds weekly & prn and daily observation to ensure care needs are met.	11/14/11

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{F 312}	Continued From page 16 Observation on October 19, 2011, at 4:12 p.m., at the Wing Two Nurses' Station, revealed the resident had bilateral hand mittens in place; Licensed Practical Nurse (LPN) #3 removed the hand mittens; the nails on the left hand were long, jagged, and sharp, and there were nail indentations observed in the palm. Interview with Licensed Practical Nurse #3 on October 19, 2011, at 4:12 p.m., at Wing Two Nurses' Station, confirmed the facility failed to provide nail care.	{F 312}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy/procedure review, and interview, the facility failed to provide appropriate incontinence care for one resident (#7) of forty-nine residents reviewed. The findings included: Resident # 7 was admitted to the facility on September 9, 2009, with diagnoses of	{F 315}	A. Resident #7 CNA's involved in this Resident's care have been re-inserviced regarding incontinence care on 11/2/11. Resident incontinence care was done correctly immediately. B. All residents have the potential to be adversely affected by this deficient process. In-servicing of the perineal care policy was completed November 14, 2011by nursing management and ongoing. C. Nursing management will complete compliance rounds and observe perineal care weekly and prn to ensure accuracy. All newly hired CNA's will have a skills check off list and will be observed by nursing management prior to end of orientation for proficiency of skill. D. Nursing management will monitor CNA compliance/knowledge of skills and policies through ongoing in-servicing and weekly and prn compliance rounds.	11/14/11

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{F 315}	Continued From page 17 Hypertension, Dementia, Sepsis and Hypothyroidism. Medical record review of the Minimum Data Set (MDS) dated September 13, 2011, revealed the resident scored a 1 on the Brief Interview of Mental Status (BIMS) which indicated the resident had severe cognitive impairment. Further medical record review revealed the resident required extensive assistance with eating, bathing and was incontinent of bladder and bowel. Observation on October 18, 2011, at 6:50 a.m., in the resident's room, revealed two Certified Nurse Assistants (CNAs) providing hygiene care following an episode of bowel and bladder incontinence. While performing perineal care, the CNAs removed the soiled brief, CNA #5 cleaned the resident's perineal area, wiping front to back, then wiped the resident's perineal area back to front two times, using the same soiled wash cloth. Further observation revealed CNA # 5 wiped the perineal front to back, dried the area with a dry towel, and placed a clean brief on the resident. Review of the facility's policy and procedure, titled Perineal Care, revealed, "...for a female resident: wash perineal area, wiping from front to back, rinse perineum thoroughly in the same direction, using fresh water and a clean washcloth..." Medical record review of the Care plan, dated September 16, 2011, revealed, "...provide or assist...with proper peri-care after each pad or brief change. Wipe from front to back to prevent intestinal bacteria from entering urinary tract: full assistance by CNA..."	{F 315}		

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{F 315}	Continued From page 18 Interview with CNA # 5 on October 18, 2011, at 7:00 a.m., in the resident's room, confirmed the perineal area was wiped back to front two times using the soiled wash cloth. Interview with the Director of Nursing (DON), on October 19, 2011, at 9:25 a.m., in the DON office, confirmed incontinence care was not provided according to facility policy.	{F 315}		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide treatment and services to prevent further decline in Range of Motion (ROM) for one resident (#3) of forty-nine residents reviewed. The findings included: Resident #3 was admitted to the facility on July 10, 2007, with diagnoses including Paraplegia, Brain Injury, and Seizure Disorder and was re-admitted to the facility on September 9, 2011, after a hospital stay from September 7, 2011 to September 9, 2011.	{F 318}	A. Resident # 3's contracture Assessment completed on 9/11/11 with no change in function. OT notified and reviewed on 10/18/11. Current ROM treatment for resident is appropriate per Restorative & OT. B. All residents with decreased ROM and/or contractures have the potential to be affected by this deficient process. Restorative nursing and OT assess residents with change of condition, hospital stay returns, and quarterly. Documentation will reflect any changes in ROM and programs will be revised to enhance or maintain current functioning. Residents have been assessed by restorative nurse and OT and no changes are needed. C. Restorative nurse aides, restorative nurse, therapy dept. rep., and nursing management will review resident level of functioning daily with care, through monthly QA reports, monthly assessments, and quarterly CP's with most appropriate intervention put in place.	11/11/11

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{F 318}	Continued From page 19 Medical record review of the Minimum Data Set (MDS) dated September 23, 2011, revealed the resident was total dependent for transfers and extensive assistance with all activities of daily living. Medical record review of the Falls Prevention Program Interventions dated March 10, 2010, and last updated March 12, 2011, revealed hand mittens were to be on at all times. Medical record review of the Interdisciplinary Plan of Care dated July 5, 2011, revealed, "...Restorative Nursing for Splinting...multiple contractures...apply bilateral hand carrots...OT (occupational therapy) to ensure appropriateness of current splint..." Medical record review of the Positioning/Splinting/ADL (activities of daily living) Screen dated September 12, 2011, revealed, "...Current Splints: B (bilateral) Hand Carrot ...B Hand carrots when hand mitts not in use..." Medical record review of the Restorative Care documentation dated September 2011, revealed, "...carrots applied September 1-7, 2011 and September 17 and 18, 2011...Gloves Applied September 11-16 and September 19-30, 2011..." Medical record review of the Restorative Care documentation dated October 2011, revealed, "...carrots applied October 2, and October 9, 2011...Gloves Applied October 1, 8, and 10-17, 2011..." Medical record review revealed since the resident's return from the hospital stay on	{F 318}	D. Review of resident functioning will be monitored daily, monthly, & quarterly by RNA's, restorative nurse, nursing management, & therapy dept. rep. Restorative and rehab treatments will be reported in monthly QA meeting.	

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{F 318}	Continued From page 20 September 9, 2011, splints had only been applied four times. Medical record review of the Restorative Care Comments revealed September 27, 2011, "...resists ROM (range of motion) conts (continues) to be extremely stiff..."; September 30, 2011, "...ROM et (and) hand carrots resumed after hosp (hospital) return...cont (continue) as stated...", and October 14, 2011, "...resident conts to wear gloves/mitts on hands unable to place carrots in hands..." Medical record review of Physician's Orders dated October 10, 2011, revealed, "...mittens at all times..." Interview with Licensed Practical Nurse #3 on October 18, 2011, at 11:55 a.m., in the Wing Two Nurses' Station, confirmed the carrots to prevent further decrease in ROM/increase in contractures had not been applied since the resident returned from the hospital and stated, "the new mittens are smaller and the carrots will not fit." Interview with Occupational Therapist on October 18, 2011, at 12:10 p.m., in the therapy room, confirmed the facility failed to assess the resident to prevent further bilateral hand contractures since the resident returned from the hospital on September 9, 2011.	{F 318}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	{F 323}	A. Resident #15 – Due to excessive wandering and unsafe behaviors in wheelchair resident sustained skin tears. Resident was one on one supervision to decrease possibility of self harm or negative interactions – which at times resulted in skin tears. One on one began October 20, 2011	11/13/11

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{F 323}	Continued From page 21 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility reports, observation, and interview the facility failed to provide supervision to prevent one resident (#15) with behavioral problems from harming self and others; failed to provide a safe transfer for one resident (#8) which resulted in the resident sustaining a right distal femur fracture; failed to use a mechanical lift when transferring resident (#3); failed to apply a soft belt restaint properly and use an appropriate transfer for resident (#5); failed to secure one of seven biohazard rooms; and failed to activate the personal alarm for resident (#14) of forty-nine residents reviewed. The facility's failure to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-323 continues at a "E" level citation (potential for more than minimal harm).	{F 323}	with staff scheduled through nursing administration & documentation reflects this also. Staff members were relieved by other staff members for breaks & lunch. Resident went into hospital 11/3/11 for unrelated medical reasons. Psych NP was consulted and saw resident on 10/10/11 – no medication changes, monitor, chart evening behavior. Resident #8 – This resident was a 4 person lift as of 6/3/11 to help minimize the risk of further injury. CNA's involved in inappropriate transfers were counseled regarding transfer & moving of resident prior to nurse assessment during investigation on 6/2/11 by nursing management and CNA's were in-serviced regarding transfers on 6/3/11 by rehab department and nursing management. Resident expired 11/13/11. Resident #3 – CP was updated 11/2/11 to include use of gait belt or mechanical lift depending on resident cooperation. Nursing staff was in-serviced on updated care plan on 11/2/11 and 11/5/11 (Baylor) by nursing management. Rehab screen completed 11/2/11 reflecting ability of resident to be transferred by gait belt. Resident #5's soft belt was immediately placed correctly on October 18, 2011. Nursing management assessed resident on 10/26/11 and an alarming seat belt	

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{F 323}	Continued From page 21 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility reports, observation, and interview the facility failed to provide supervision to prevent one resident (#15) with behavioral problems from harming self and others; failed to provide a safe transfer for one resident (#8) which resulted in the resident sustaining a right distal femur fracture; failed to use a mechanical lift when transferring resident (#3); failed to apply a soft belt restaint properly and use an appropriate transfer for resident (#5); failed to secure one of seven biohazard rooms; and failed to activate the personal alarm for resident (#14) of forty-nine residents reviewed. The facility's failure to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-323 continues at a "E" level citation (potential for more than minimal harm).	{F 323}	was placed, this was care planned and in-servicing of CNA's done on 10/26/11. CNA's performing inappropriate transfer and moving resident prior to nurse assessment were counseled on 10/18/11 and in-serviced on 10/19/11 by nursing management an rehab department. Biohazard room key was moved from near the door to the nurses desk. Sign above doorknob states "See nurse for key." Key was removed from door October 18, 2011. Resident #14 – the alarm was activated on October 18, 2011. A new alarm chair pad with activation inside the box was placed on resident 11/2/11 to ensure activation. Alarm checks are done by CNA's during walking rounds routinely during daily care and a light flashes when battery is needed. The CNA's are in-serviced as new alarms are placed by nursing management. Alarms placement is tracked through QA nurse and alarms are discussed during weekly sub QA meeting. In-servicing began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. B. All residents have the potential to be adversely affected by this deficient process. Residents at risk are identified by incident reports, rehab	

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{F 323}	Continued From page 21 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility reports, observation, and interview the facility failed to provide supervision to prevent one resident (#15) with behavioral problems from harming self and others; failed to provide a safe transfer for one resident (#8) which resulted in the resident sustaining a right distal femur fracture; failed to use a mechanical lift when transferring resident (#3); failed to apply a soft belt restaint properly and use an appropriate transfer for resident (#5); failed to secure one of seven biohazard rooms; and failed to activate the personal alarm for resident (#14) of forty-nine residents reviewed. The facility's failure to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-323 continues at a "E" level citation (potential for more than minimal harm).	{F 323}	done on 11/7/11 by nursing management with no further action needed. CNA round sheets include checking of alarms. All other 6 biohazard doors were checked by environmental service director and keys moved & signs placed where no key pad is in place. Residents at risk are reviewed in weekly sub QA meeting with nursing management, rehab, SS staff, medical director, pharmacy consultant. Supervision to: prevent behavior issues resulting in harm to self & others, prevent inappropriate transfers resulting in harm, using transfer recommendations appropriate for residents, applying ordered appropriate restraint properly, securing biohazard rooms, and appropriate alarms in working order & activated, will be provided by nurses, nursing staff, nursing management, psych NP, therapy dept., social services, activities, administrator, MD/NP, medical director by in-servicing at monthly mandatory meetings as needed by occurrence. Nursing management will do compliance rounds/ daily observation and will make referrals to therapy, social service dept. and psych NP as needed. Review of residents identified at risk will be done weekly with this team & medical director as resident need dictates.	

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{F 323}	Continued From page 21 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility reports, observation, and interview the facility failed to provide supervision to prevent one resident (#15) with behavioral problems from harming self and others; failed to provide a safe transfer for one resident (#8) which resulted in the resident sustaining a right distal femur fracture; failed to use a mechanical lift when transferring resident (#3); failed to apply a soft belt restaint properly and use an appropriate transfer for resident (#5); failed to secure one of seven biohazard rooms; and failed to activate the personal alarm for resident (#14) of forty-nine residents revlewed. The facility's failure to supervise resident #15 and address the resident's unsafe behaviors in the use of the wheelchair placed the residents on Wing # I and # IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-323 continues at a "E" level citation (potential for more than minimal harm).	{F 323}	C. Supervision will be by observation, assessment and by following plan of care on a daily basis by weekly meetings and quarterly assessments (MDS). Interventions and/or changes will be in place and staff notified at that time by appropriate dept. D. Behaviors, resident to resident altercations, restraints, alarms, change in condition of resident will be reviewed by IDT in weekly meetings and with daily observations by nurses, nursing management, therapy staff, activity staff, dietary staff, environmental services staff, social service staff, and administration. QA meetings will report trends in behaviors, bruises, unknown origin incidents, and report on restraints and alarms and interventions taken throughout the month. In-servicing will occur at monthly mandatory meetings and as incidents occur.	

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{F 323}	Continued From page 22 Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of the behavior management policy and procedure, observations, and interviews with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility's inservice for behavior management policy and procedures was reviewed. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 323}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	{F 329}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

11/15/2011
FORM APPROVED
OMB NO. 0938-0391

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{F 329}	Continued From page 23 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to implement a physician's order timely, resulting in the administration of unnecessary anti-anxiety and anti-psychotic medication doses for one resident (#23) of forty-nine residents reviewed. The findings included: Resident #23 was admitted to the facility with diagnoses including Alzheimer's Dementia and Aphasia. Medical record review of the Minimum Data Set (MDS) dated October 4, 2011, revealed no behaviors were exhibited. Medical record review of the Physician's Communication Form dated June 20, 2011, revealed "...attempt periodic dose reduction...current dose of Lorazepam (anti-anxiety) 0.5 mg. (milligram) ½ tab (half tablet) (0.25) BID (twice daily)...consider Lorazepam 0.5 mg. ½ (0.25 mg.) QD (every day)...Physicians Response: Will try...date 7-13-11..."	{F 329}	A. Resident #23 the physician ordered dose was given on September 11, 2011 for Lorazepam and on October 11, 2011 for Risperidone and continues to be given as ordered. B. All residents with med changes have the potential to be adversely affected by this deficient process. Chart checks will be completed and noted Q day by charge nurses assuring orders are noted & completed. C. A new protocol for chart checks was instituted & in-serviced by nursing management on how to audit with completion by 11/14/11 and during chart audits nursing management will review for accuracy. D. Nursing management will review charts for accuracy during chart audits weekly, monthly and prn. They will use pharmacy faxes, nurses 24 hour report and lab requisitions to review also.	11/14/11

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{F 329}	Continued From page 24 Medical record review of the Medication Administration Record (MAR), dated August 1, 2011, revealed the resident continued to receive Lorazepam 0.25 mg BID from July 13, 2011 until September 11, 2011, resulting in twenty-six unnecessary doses of Lorazepam 0.25mg. Medical record review of the Physician's Communication Form, completed by the pharmist, dated September 12, 2011, revealed "...attempt periodic dose reduction...Risperidone (anti-psychotic) 1mg (milligram) HS (nightly)...try Risperidone 0.5mg HS...Physicians Response: OK to try dose reduction...dated 10/6/11..." Medical record review of the MAR dated October 1, 2011, revealed the resident continued to receive Risperidone 1mg at HS from October 6, 2011, until October 11, 2011, resulting in five unnecessary doses of Risperidone 1mg. Interview with Registered Nurse #1 on October 20, 2011, at 9:00 a.m., in Wing Two Nurses' Station, confirmed the facility failed to follow physician's orders for a dose reduction until September 11, 2011, for Lorazepam, resulting in twenty-six unnecessary doses, and October 11, 2011 for Risperidone, resulting in five unnecessary doses.	{F 329}		
{F 428} SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	{F 428}		

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{F 428}	Continued From page 25 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to follow pharmacy consultant recommendations for dose reductions in a timely manner for one resident (#23) of forty-nine residents reviewed. The findings included: Resident #23 was admitted to the facility with the diagnoses including Alzheimer's Dementia and Aphasia. Medical record review of the Minimum Data Set (MDS) dated October 4, 2011, revealed the resident had short and long term memory problems, and no behaviors were exhibited. Medical record review of the Physician's Communication Form completed by the pharmacist with recommendations related to medications dated June 20, 2011, revealed, "...attempt periodic dose reduction...current dose of Lorazepam (anti-anxiety) 0.5 mg. (milligram) ½ tab (half tablet) (0.25 mg.) BID (twice daily)...consider Lorazepam 0.5 mg. ½ (0.25 mg.) QD (every day)...Physicians Response: Will try...date 7-13-11 (more than three weeks later)..." Medical record review of the Physician's	{F 428}	A. Resident #23 was given correct dose ordered by 10/11/11. Pharmacy consultant and DON reviewed protocol on 11/4/11 and monthly reviews will now be to MD/NP within 7-10 days of review or sooner with complexity and urgency of request related to medical issues. B. All residents have the potential to be adversely affected by this deficient process. Protocol has been updated so monthly reviews will be to MD/NP's within 7-10 days of review. Consultant will print review & recommendations every week or sooner as severity demands to be given to MD/NP. Recommendations will be processed immediately after MD/NP review. C. New recommendation forms time table will be implemented by 11/11/11, where monthly reviews will be generated weekly or sooner as completed. D. Nursing management and pharmacy consultant will monitor for compliance on a weekly basis.	11/11/11

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{F 428}	Continued From page 26 Communication Form completed by the pharmacist, dated September 12, 2011, revealed "...attempt periodic dose reduction...Risperidone (anti-psychotic) 1mg (milligram) HS (nightly)...try Risperidone 0.5mg HS...Physicians Response: OK to try dose reduction...dated 10/6/11 (more than three weeks later)..." Interview with Registered Nurse #1 on October 20, 2011, at 9:00 a.m., in Wing Two Nurses' Station, confirmed the facility failed to notify the physician of the pharmacist recommendations for dose reduction for the Lorazepam and Risperidone.	{F 428}		
{F 431} SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	{F 431}		

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{F 431}	Continued From page 27 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility policy, and interview, the facility failed to separate medications and food and discard expired laboratory supplies in four of four medication rooms, and failed to discard expired laboratory supplies in one of seven biohazard rooms. The findings included: Observation and interview with Licensed Practical Nurse (LPN) #9, of the wing four medication room, on October 19, 2011, at 10:00 a.m., revealed six blue top specimen tubes with an expiration date of August, 2011, available for resident use. Observation and interview with Registered Nurse (RN) #1, of the wing two medication room, on October 19, 2011, at 10:15 a.m., revealed 100 red top specimen tubes with an expiration date of August, 2011, available for resident use. Observation and interview with LPN #7, of the	{F 431}	A. Food was removed from medicine refrigerators on October 19, 2011. All expired lab vials/swabs were discarded on October 19, 2011. Facility policy updated 11/7/11 to reflect no food in refrigerator with meds. B. All residents have the potential to be adversely affected by this deficient process. Routine inspections, weekly, monthly, & prn, will be conducted by nursing management & pharmacy consultant in regards to food storage & outdated supplies. In-servicing to nurses was completed November 14, 2011by nursing management & ongoing. C. Nursing management will complete compliance rounds along with pharmacy consultant every week and as needed to ensure compliance. Lab services will be notified of supplies needed to supplies will be checked by nursing staff when received. D. Nursing management, pharmacy consultant, & charge nurses will monitor for compliance daily.	11/14/11

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{F 431}	Continued From page 28 biohazard room on wing one, on October 19, 2011, at 10:15 a.m., revealed 98 blue top specimen tubes with an expiration date of September, 2011, available for resident use. Observation and interview with LPN #8, of the wing one medication room, on October 19, 2011, at 10:25 a.m., revealed the following in the medication refrigerator: two, unopened, 10 ml (milliliter) vials of Lantus insulin; one box of Acetaminophen suppositories, 650 mg (milligrams); one 20 mcg (microgram) Forteo pen; two unopened 10 ml vials Novolin R insulin; thirty-seven 8 ounce cans nephro supplement; eighteen 32 fluid ounce cartons of Resource 2.0 supplement; fifteen 8 ounce cans of boost glucose control; and 15 cups of pudding. Observation and interview with LPN #6, of the secure unit medication room, on October 19, 2011, at 10:30 a.m., revealed the following in the medication refrigerator; 1 one ml vial promethazine; ninety 10mg Bisacodyl suppositories; one bottle Lactinex, unopened; and 8 cups of pudding. Continued observation and interview revealed five culture swabs with an expiration date of April, 2011, available for resident use. Review of the facility policy, Medication Storage in the Facility, revealed, "...Refrigerated medications are kept in closed and labeled containers...separate from fruit juices, applesauce, and other foods used in administering medications. Other foods...are not stored in this refrigerator..." Interview on October 19, 2011, at 10:20 a.m.,	{F 431}		

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{F 431}	Continued From page 29 with the Director of Nursing (DON) in the DON's office confirmed medications are not to be stored with food.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	{F 441}	A. Resident #18 dressing change was addressed by nursing administrations with treatment nurses immediately on October 19, 2011 with policy reviewed. Resident #19's charge nurse was counseled on 10/19/11by nursing management regarding not giving any meds other than po meds in dining room. Employees passing ice water were instructed on proper way to pass ice water on 10/19/11 by nursing management. B. All residents have the potential to be adversely affected by this deficient process. In-servicing was done by 11/14/11by nursing management regarding dressing changes, infection control policy, gloves, hand washing, & passing ice water. In-services also will be ongoing. C. Compliance rounds by nursing management, infection control nurse, pharmacy consultant will be completed weekly & prn to ensure compliance. Also daily observation will be done & any deficient issues will be corrected immediately.	11/14/11

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{F 441}	Continued From page 30 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to follow the facility's policy for Infection Control during a dressing change for one resident (#18) of forty-nine reviewed; failed to maintain infection control during a medication administration for one resident (#19); and failed to maintain infection control during ice pass on the one-hundred hall for six observed residents. The findings included: Observation on October 19, 2011, at 8:20 a.m., revealed resident #19 seated at a table with three other residents eating the breakfast meal. Continued observation revealed Licensed Practical Nurse (LPN) #1 approached the resident and administered an insulin injection into the resident's left arm without wearing gloves, returned to the medication cart and used hand sanitizer. Review of the facility's policy Subcutaneous Medication Administration Procedures revealed "...Wash hands and put on gloves...Prepare medication...Inject medication slowly...Remove gloves. Wash hands..." Review of the facility's policy Using Gloves revealed "...Objectives: 1. To prevent the spread of infection and disease to residents and	{F 441}	D. Nursing management, infection control nurse, charge nurses, pharmacy consultant, and QA nurse will monitor for infection control issues. In-servicing will be ongoing and compliance will be monitored by in-service attendance and observation.	

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{F 441}	Continued From page 31 employees...When to Use Gloves:...When touching excretion, secretions, blood, body fluids, mucous membranes, or non-intact skin..." Interview on October 19, 2011, at 8:25 a.m., with LPN #1, in the dining room, revealed gloves were to be worn when administering injections, and confirmed gloves were not worn when the insulin injection was administered to the resident. Resident #18 was admitted to the facility on December 15, 2010, with diagnoses including Left Lower Quadrant Open Abscess, Acute Renal Failure, Sepsis, Chronic Obstructive Pulmonary Disease, and Dementia. Observation on October 19, 2011, at 9:48 a.m., revealed treatment nurse #1 and treatment nurse #2 administering a dressing change to resident #18. Observation revealed treatment nurse #1 removed a visibly soiled dressing from the resident's perineal area, failed to wash the hands or don gloves, and returned to the already established clean field. Continued observation of the residents' perineal area revealed two fistula openings in the left lower quadrant. Observation of the dressing change at this time revealed treatment nurse #1 retrieved a cotton swab and inserted the cotton swab into the medial fistula. Further observation revealed treatment nurse #1 then used the same cotton swab and inserted into the lateral fistula. Review of the facility policy for Dressing Changes revealed "...loosen tape and remove soiled dressing...pull glove over dressing and discard into appropriate receptacle...wash	{F 441}		

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{F 441}	Continued From page 32 hands...Cleanse the wound. Use separte gauze for each cleansing stroke. Clean from the least contaminated to the most contaminated area..." Interview on October 19, 2011, at 10:30 a.m., outside the Director of Nursing (DON) office with the DON confirmed the facility failed to follow the policy and procedure for dressing changes. Observation on October 19, 2011, at 10:00 a.m., on Wing 1 hallway, revealed Certified Nursing Assistant (CNA) #3 filling ice water pitchers with ice outside three separate resident rooms. Further observation revealed CNA # 3 went into each resident's room, took each resident water pitcher outside the room (two residents per room), placed the ice scoop below the rim and inside each pitcher (pitchers already used by the residents), and without cleaning the scoop between residents, returned the pitchers into the room and exited without sanitizing the hands between residents. Interview with CNA # 3, on October 19, 2011, at 10:00 a.m., on Wing 1 hallway, confirmed the pitchers had been used by residents and the scoop was contaminated when placed inside the water pitchers. Further interview confirmed the CNA had not sanitized the hands between residents. Interview with the Director of Nursing (DON), on October 19, 2011, at 3:00 p.m., in the DON office, confirmed the ice scoop was contaminated when placing ice into the resident's water pitcher and the CNA was to sanitize the hands between resident rooms. Further interview confirmed the	{F 441}		

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{F 441}	Continued From page 33 CNA failed to follow standard infection control practice.	{F 441}		
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, facility policy review, and interview, the facility failed to be administered in a manner to ensure an effective system was in place to investigate injuries of unknown origin were thoroughly investigated, resulting in an injury of unknown origin not being thoroughly investigated for one (#12) resident, failed to ensure the supervision and safe use of a wheelchair for one (#15) resident in order to prevent the resident from harming self and others, and failed to ensure social services were provided for residents (#12, #15, #27, #30) with behaviors for forty-nine residents reviewed which placed resident #12, #15, #27, & #30 in Immediate Jeopardy (a situation in which a provider's non-compliance has caused, or is likely to cause serious harm, injury, impairment, or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy.	{F 490}	A. Resident #3 – CP was updated 11/2/11 to include use of gait belt or mechanical lift depending on resident cooperation. Nursing staff was in-serviced on updated care plan on 11/2/11 and 11/5/11 (Baylor) by nursing management. Rehab screen completed 11/2/11 reflecting ability of resident to be transferred by gait belt. Resident #5's soft belt was immediately placed correctly on October 18, 2011. Nursing management assessed resident on 10/26/11 and an alarming seat belt was placed, this was care planned and in-servicing of CNA's done on 10/26/11. Biohazard room key was moved from near the door to the nurses desk. Sign above doorknob states "See nurse for key." Key was removed from door October 18, 2011. Resident #8 – CNA's performing inappropriate transfer and moving resident prior to nurse assessment were counseled on 10/18/11 and in-serviced on 10/19/11 by nursing management and rehab department. This resident was a 4 person transfer as of 6/3/11 & nursing staff was in-serviced by rehab on that date. CP updated for transfer needed. Resident expired 11/13/11. In-servicing began on 10/28/11 and all staff to be in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Resident #14 – the alarm was activated on October 18, 2011. A new alarm chair pad with activation inside the box was placed on resident 11/2/11 to ensure activation.	11/13/11

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{F 490}	Continued From page 34 Non-compliance for F-490 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observations, and interviews with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided evidence of a completed investigation of the bruising of unknown origin of resident #12. In addition, the Assistant Director of Nursing (ADON) provided the findings and conclusions from the investigations of forty-four additional injuries of unknown origin. The ADON provided the methods adopted to facilitate the identification of all injuries of unknown origin, communication to all responsible parties, investigation of the injuries to a conclusion, and the system to track and trend the injuries. The facility provided new policies/procedures including a policy for investigation of injuries of unknown origin adopted as part of the abuse policy, The facility provided evidence of in-service education for all staff. The facility provided new policies/procedures including a policy for Behavior Management. The facility provided evidence of in-service education for all staff for the adopted behavior management policy and for specific resident behavior management plans, The individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 27, and 30. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of	{F 490}	Alarm checks are done by CNA's during walking rounds routinely during daily care and a light flashes when battery is needed. The CNA's are in-serviced as new alarms are placed by nursing management. Alarms placement is tracked through QA nurse and alarms are discussed during weekly sub QA meeting. Resident #24 – Bruising to breast related to wheelchair has been assessed by nursing and rehab and a different w/c was issued to resident on 11/4/11. This w/c is tagged with resident name & staff in-serviced by CM on chair & positioning on 11/4/11. Put on CNA CP also. Nursing staff will observe at least every 2 hours on rounds & prn regarding positioning in w/c and ask resident regarding comfort. Bruising and prevention has been added to CP by nursing management after assessment as of 10/31/11. Resident #12 - Discovered bruise on July 22, 2011. Clinical manager reviewed accounts July 25, 2011 given by nurse and CNA on duty during initial discover. ADON reviewed account on July 25, 2011. Reopened investigation 10/28/11. ADON re-interviewed nurses and CNA's on duty during initial discovery. Investigation was completed 11/1/11. No other action was required. No intentional injury occurred based on resident behavior or reaction to others were unchanged, no further incident of this type has recurred. Abuse coordinator reviewed all documentation on 11/1/11 of investigation and no abuse was substantiated per clinical assessment. The medical director was notified by DON on October 25, 2011. NP was notified by DON on October 28, 2011. Medical director & NP were notified of investigation completion	

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{F 490}	Continued From page 34 Non-compliance for F-490 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observations, and interviews with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided evidence of a completed investigation of the bruising of unknown origin of resident #12. In addition, the Assistant Director of Nursing (ADON) provided the findings and conclusions from the investigations of forty-four additional injuries of unknown origin. The ADON provided the methods adopted to facilitate the identification of all injuries of unknown origin, communication to all responsible parties, investigation of the injuries to a conclusion, and the system to track and trend the injuries. The facility provided new policies/procedures including a policy for investigation of injuries of unknown origin adopted as part of the abuse policy. The facility provided evidence of in-service education for all staff. The facility provided new policies/procedures including a policy for Behavior Management. The facility provided evidence of in-service education for all staff for the adopted behavior management policy and for specific resident behavior management plans. The individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 27, and 30. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of	{F 490}	on 11/8/11 by DON. No further orders were given. State guardian was notified 11/1/11. In-servicing on abuse policy, unknown origin, and behavior management policy began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Revised abuse policy on November 6, 2011 was combining unknown injuries/accident incidents to be included in policy. No new information was added. State was notified of incident & investigation through IRS system on 11/7/11. Has had a behavior component added to her Care Plan 10/28/11 by social service assistant assigned to that resident. After SS director (LCSW) assessed resident, on 10/28/11 an individualized written behavior management plan was formulated, and then SS director in-serviced nursing staff on plan and placed plan in chart on 10/28/11 and also copy of plan placed in Behavior Sheets book at nurses station. Resident #27 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. Resident #30 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written	

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{F 490}	Continued From page 34 Non-compliance for F-490 continues at a "E" level citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observations, and interviews with the Licensed Counseling Social Worker, nurses, and administrative staff. The facility provided evidence of a completed investigation of the bruising of unknown origin of resident #12. In addition, the Assistant Director of Nursing (ADON) provided the findings and conclusions from the investigations of forty-four additional injuries of unknown origin. The ADON provided the methods adopted to facilitate the identification of all injuries of unknown origin, communication to all responsible parties, investigation of the injuries to a conclusion, and the system to track and trend the injuries. The facility provided new policies/procedures including a policy for investigation of injuries of unknown origin adopted as part of the abuse policy, The facility provided evidence of in-service education for all staff. The facility provided new policies/procedures including a policy for Behavior Management. The facility provided evidence of in-service education for all staff for the adopted behavior management policy and for specific resident behavior management plans, The individual behavior management plans and the coinciding comprehensive care plans were reviewed for residents #12, 27, and 30. Resident #15 had been dismissed from the facility. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of	{F 490}	behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. Resident #15 has had a behavior component added to his care plan 10/27/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, on 10/27/11an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. One on one was already in place and continuing until out to hospital for unrelated medical issues on 11/3/11. All in-servicing of all staff who are not on vacation or on leave has been in-serviced on abuse policy, incidents of unknown origin policy, and behavior management policy by 11/7/11, returning staff will be in-serviced on day of return. Agency staff will be in-serviced prior to start of shift. B. All residents have the potential to be adversely affected by this deficient process. The administrator will review each incident report and will be part of the investigation of unknown origin incidents along with nursing admin, abuse coordinator (SS director), SS staff, MD/NP, Dept. Directors as appropriate and medical director. C. Each incident of unknown origin & behavior issues will be reviewed daily upon occurrence. Also incidents of unknown origin, behavior issues, restraint application/elimination and alarm application/elimination will be reviewed weekly at sub QA meetings. The administrator attends all weekly sub QA meetings unless outside facility and receives reports as	

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{F 490}	Continued From page 35 correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}		
{F 497} SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and interview, the facility failed to provide twelve hours of inservice education per year for twenty seven, of one hundred twenty Certified Nurse Assistants (CNA) currently employed. The findings included: Review of Facility documentation from June 2010 - July 2011 revealed a list of the current employed CNAs, and the total in-service hours during the time frame. Further review revealed	{F 497}	A. In-servicing began on October 25, 2011 for those 27 CNA's who have not received 12 hours of in-service education in the past year. In-servicing was done by nursing management, social service staff, environmental service staff and rehab staff. In-servicing is ongoing and compliance will be met on November 20, 2011 for all CNA's, B. All CNA's have the potential to not have requirements met by this deficient process. A new form was developed to track CNA in-services on 10/27/11 and CNA evaluations will be held until requirement met. C. In-services will be logged onto new form at least weekly and CNA's will be notified of in-service meetings/labs being conducted. Nursing management will review in-service hours monthly to ensure compliance. D. Timely documentation of in-service attendance and monthly review of in-service log book will be completed by nursing management.	11/20/11

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{F 497}	Continued From page 36 twenty-seven of the one hundred twenty CNAs listed did not have the twelve hours of the required in-service education. Interview with the Assistant Director of Nursing (ADON) on October 24, 2011, at 11:30 a.m., in the Director of Nursing (DON) office, confirmed the facility failed to calculate the total number of in-service hours in July 2011 and the ADON was unsure if all the CNAs had the required in-service education. The ADON stated "had not done for quite some time" when interviewed about determining the hours of the CNAs.	{F 497}		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate medical record for one (#20) of forty-nine residents. The findings included:	{F 514}	A. Resident #20 The DNR sticker at the front of the chart was immediately removed. B. All residents have the potential to be adversely affected by this deficient process. In-servicing by nursing administration of nurses and SS Director was completed by 11/7/11 and will be ongoing regarding any time a POST is completed or updated the person updating this form is responsible for applying or removing DNR sticker. All charts were reviewed by nursing mangement 11/7/11 with all charts being accurate. C. Nursing management and medical records employee will ensure stickers are correct on chart during chart audits which are routinely conducted on admission, hospital return, and monthly.	11/11/11

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{F 514}	Continued From page 37 Resident #20 was re-admitted to the facility on February 6, 2011, with diagnoses including Bipolar Disorder, Diabetes, and Chronic Obstructive Pulmonary Disease. Medical record review of a POST (Physicians Order for Scope of Treatment) dated and signed by the physician on September 2, 2010, revealed the resident was to be a full code. Medical record review revealed the record was flagged with two stickers stating, "DNR" (do not resuscitate). Interview with the Director of Nursing (DON), in the DON's office on October 19, 2011, at 3:00 p.m., confirmed the resident was to be a full code and the medical record was inaccurate.	{F 514}	D. Accuracy of chart stickers will be monitored by nursing management with monthly and prn chart audits. DON will receive notification when POST is taken to MD, and chart will be reviewed at that time assuring accuracy.	
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	{F 520}	A. Resident #3 – CP was updated 11/2/11 to include use of gait belt or mechanical lift depending on resident cooperation. Nursing staff was in-serviced on updated care plan on 11/2/11 and 11/5/11 (Baylor) by nursing management. Rehab screen completed 11/2/11 reflecting ability of resident to be transferred by gait belt. Resident #5's soft belt was immediately placed correctly on October 18, 2011. Nursing management assessed resident on 10/26/11 and an alarming seat belt was placed, this was care planned and in-servicing of CNA's done on 10/26/11. Biohazard room key was moved from near the door to the nurses desk. Sign above doorknob states "See nurse for key." Key was removed from door October 18, 2011. Resident #8 – CNA's performing	11/13/11

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{F 520}	Continued From page 38 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assurance Committee meeting minutes; Weekly Skin Reports; reports filed for residents' skin tears and bruising; and resident to resident altercations; observation; and interview, the facility failed to ensure the Quality Assurance Committee identified potential areas of concern and implemented a plan to address the areas of concern. The facility's failure to address residents' safety by reviewing and developing data in the aggregate to assist in formulating improvement plans (for individual residents and for specific populations of residents) placed residents on Wing I and IV in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on November 8, 2011. A revisit conducted on November 10, 2011, revealed the corrective actions implemented on November 8, 2011, removed the Immediate Jeopardy. Non-compliance for F-520 continues at a "E" level	{F 520}	inappropriate transfer and moving resident prior to nurse assessment were counseled on 10/18/11 and in-serviced on 10/19/11 by nursing management and rehab department. This resident was a 4 person transfer as of 6/3/11 & nursing staff was in-serviced by rehab on that date. CP updated for transfer needed. Resident expired 11/13/11. In-servicing began on 10/28/11 and all staff to be in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Resident #14 – the alarm was activated on October 18, 2011. A new alarm chair pad with activation inside the box was placed on resident 11/2/11 to ensure activation. Alarm checks are done by CNA's during walking rounds routinely during daily care and a light flashes when battery is needed. The CNA's are in-serviced as new alarms are placed by nursing management. Alarms placement is tracked through QA nurse and alarms are discussed during weekly sub QA meeting. Resident #24 – Bruising to breast related to wheelchair has been assessed by nursing and rehab and a different w/c was issued to resident on 11/4/11. This w/c is tagged with resident name & staff in-serviced by CM on chair & positioning on 11/4/11. Put on CNA CP also. Nursing staff will observe at least every 2 hours on rounds & prn regarding positioning in w/c and ask resident regarding comfort. Bruising and prevention has been added to CP by nursing management after assessment as of 10/31/11. Resident #12 - Discovered bruise on July 22, 2011. Clinical manager reviewed accounts July 25, 2011 given by nurse and CNA on duty during initial discover.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY HEALTH CARE & REHAB	2910 PEERLESS RD CLEVELAND, TN 37312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 520}	Continued From page 39 citation (potential for more than minimal harm). Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observations, and interviews with the Licensed Counseling Social Worker, nurses, and administrative staff. The Assistant Director of Nursing provided the methods adopted to facilitate the identification of all injuries of unknown origin, communication to all responsible parties, investigation of the injuries to a conclusion, and the system to track and trend the injuries. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 520}	ADON reviewed account on July 25, 2011. Reopened investigation 10/28/11. ADON re-interviewed nurses and CNA's on duty during initial discovery. Investigation was completed 11/1/11. No other action was required. No intentional injury occurred based on resident behavior or reaction to others were unchanged, no further incident of this type has recurred. Abuse coordinator reviewed all documentation on 11/1/11 of investigation and no abuse was substantiated per clinical assessment. The medical director was notified by DON on October 25, 2011. NP was notified by DON on October 28, 2011. Medical director & NP were notified of investigation completion on 11/8/11 by DON. No further orders were given. State guardian was notified 11/1/11. In-servicing on abuse policy, unknown origin, and behavior management policy began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Revised abuse policy on November 6, 2011 was combining unknown injuries/accident incidents to be included in policy. No new information was added. State was notified of incident & investigation through IRS system on 11/7/11. Has had a behavior component added to her Care Plan 10/28/11 by social service assistant assigned to that resident. After SS director (LCSW) assessed resident, on 10/28/11 an individualized written behavior management plan was formulated, and then SS director in-	

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